



State of Nevada
Victims of Crime Program

Request for Pre-Authorization for Payment

Submit this form when requesting pre-authorization for payment for services to victim for any crime related expense

Victim/Patient Name:

VOCP Claim #

Service or Treatment Information:

Description of service or treatment: (include CPT and HCPCS codes) Attach Billing Documents.

What is the cost, or estimated cost of this service or treatment?

Is this service or treatment necessitated by the crime?

☐ Yes

☐ No If No please explain:

Is any portion of this covered by Insurance, or did the Applicant/Victim pay any portion of this claim?

☐ Yes If Yes please explain:

☐ No

The information provided herein is true and accurate to the best of my information and belief

Authorized Signature:

Print Signers Name:

Date:

Tele:

Fax:

E-mail:

Mail to: VOCP
P O Box 94525
Las Vegas, NV 89193-1525

Fax to:
(702) 458-5586

Scan and email to:
applications@voc-net.com

VOCP Pre-Authorization for Payment for Treatment or Services:

This Authorization is only valid for 60 days after date approved by the Compensation Officer.

VOCP Decision:

☐ *Approved*

☐ *Denied*

Amount Approved: \$

Date CCSI Review:

Compensation Officer Signature: (Required for approval)

Date: